# CCS/GHPP DISCHARGE PLANNING SERVICE AUTHORIZATION REQUEST (SAR)

## Hospital Information

| 1. Date of request | 2. Hospital name | 3. Medi-Cal provider number |
|---|---|---|
| | | |

| 4. Address (number, street) | City | State | ZIP code |
|---|---|---|---|
| | | | |

| 5. Contact person/discharge planner | 6. Telephone number ( ) | 7. Fax number ( ) |
|---|---|---|
| | | |

## Client Information

8. Client name—last first middle

| 9. Alias (AKA) | 10. Gender ☐ Male ☐ Female | 11. Date of birth (mm/dd/yyyy) |
|---|---|---|
| | | |

| 12. CCS/GHPP case number | 13. Contact phone number ( ) | 14. Medical record number (hospital or office) |
|---|---|---|
| | | |

| 15. Residence address (number, street) *(DO NOT USE P.O. BOX)* | City | State | ZIP code |
|---|---|---|---|
| | | | |

| 16. Mailing address (if different) (number, street, P.O. box number) | City | State | ZIP code |
|---|---|---|---|
| | | | |

| 17. County of residence | 18. Language spoken | 19. Name of parent/legal guardian |
|---|---|---|
| | | |

| 20. Mother's first name | 21. Primary care physician (if known) | 22. Primary care physician telephone number ( ) |
|---|---|---|
| | | |

## Insurance Information

| 23.a. Enrolled in Medi-Cal? ☐ Yes ☐ No | 23.b. If yes, client index number (CIN) | 23.c. Client's Medi-Cal number |
|---|---|---|
| | | |

| 24. Enrolled in Healthy Families? ☐ Yes ☐ No | If yes, name of plan |
|---|---|
| | |

| 25. Enrolled in commercial insurance plan? ☐ Yes ☐ No | If yes, type of commercial insurance plan ☐ PPO ☐ HMO ☐ Other | Name of plan |
|---|---|---|
| | | |

26. Diagnosis

27. Plan to discharge to: ☐ Home ☐ Transfer to (specify): _____

## Specific Discharge Planning Services Requested

**28. Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person

Address | City | State | ZIP code

Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Quantity

Additional information | Frequency/duration

**29. Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person

Address | City | State | ZIP code

Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Quantity

Additional information | Frequency/duration

| 30. Signature of discharge planner | 31. Title |
|---|---|
| | |

| 32. Name of discharging physician | 33. Date |
|---|---|
| | |

| 34. Client name—last | first | middle |
|---|---|---|

| 35. Date of request | 36. Contact person/discharge planner | 37. Telephone number ( ) |
|---|---|---|

## Specific Discharge Planning Services Requested *(continued)*

| **38. Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person |
|---|---|---|---|
| Address | | City | State / ZIP code |
| Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Quantity |
| Additional information | Frequency/duration | | |

| **39. Provider's name** | Medi-Cal provider number | Telephone number ( ) | Contact person |
|---|---|---|---|
| Address | | City | State / ZIP code |
| Description of services | EPSDT SS? ☐ Yes ☐ No | Procedure code | Quantity |
| Additional information | Frequency/duration | | |

| 40. Signature of discharge planner | 41. Title |
|---|---|

| 42. Name of discharging physician | 43. Date |
|---|---|

## INSTRUCTIONS

1. and 35. Date of request: Date the request is being made.

### Hospital Information

2. Hospital name: Enter the legal name of the hospital who is requesting the services.
3. Medi-Cal provider number: Enter inpatient Medi-Cal billing number.
4. Address: Enter the hospital's address.
5. and 26. Contact person: Enter the name of the person who can be contacted regarding the request.
6. and 37. Contact person telephone number: Enter the phone number of the contact person.
7. Fax number: Enter the fax number of the hospital or contact person.

### Client Information

8. and 34. Client name: Enter the client's name, last, first, and middle.
9. Alias (AKA): Enter patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's CCS/GHPP number. If number not known, leave blank.
13. Contact phone number: Enter the phone number where the client's parent/legal guardian can be reached.
14. Medical record number: Enter the patient's hospital or office medical number.
15. Residence address: Enter the client's address. Do not use a P.O. Box number.
16. Mailing address: Enter mailing address if different than 15.
17. County of residence: Residential county of the client.
18. Language spoken: Enter the client's language spoken
19. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
20. Mother's first name: Enter the client's mother's first name.
21. Primary care physician: Enter client's primary care physician's name; if it is not known, enter NK (not known).
22. Primary care physician telephone number: Enter client's primary physician's phone number.

### Insurance Information

23. Enrolled in Medi-Cal? Check the appropriate box. If the answer is yes, enter the client's index number in box 23.b. and the client's Medi-Cal number in box 23.c.
24. Enrolled in Healthy Families? Check the appropriate box. If the answer is yes, enter the name of the plan.
25. Enrolled in a commercial insurance plan? Check the appropriate box. If the answer is yes, check type of commercial insurance plan and enter the name of the insurance plan on the line provided.

### Diagnosis/Discharge Plan

26. Diagnosis: Enter the diagnosis, if known, relating to the requested services.
27. Plan to discharge: Check the appropriate box. If "transfer to" is checked, please specify where on line provided.

### Specific Discharge Planning Services Requested

28., 29, 38., and 39. Provider's name: Enter name of the provider who will be performing the services requested.
Medi-Cal provider number: Enter the provider's Medi-Cal provider number.
Telephone number: Enter phone number of the provider.
Contact person: Enter name of contact person at the provider's office.
Address: Enter provider's address.
Description of services: Describe service that is being requested.
EPSDT SS?: Check appropriate box. If yes, contact the State for prior authorization.
Procedure code: Enter the procedure code for the service being requested.
Quantity: Enter the number of times the procedure/service code is requested. The procedure/service code requested will indicate the length of time for each. For drug requests, the quantity should be the amount to be dispensed per prescription.
Additional information: Include any written details/instructions here.
Frequency/duration: Enter the frequency or duration of the procedures/services being requested.

### Signature

30. and 40. Signature of discharge planner: Discharge planner signs here.
31. and 41. Title: Enter the title of person signing the document.
32. and 42. Name of discharging physician: Enter the name of the discharging physician.
33. and 43. Date: Enter the date signed.